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ANA Board of Directors
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ANA Board of Directors Task Force on Interstate Practice

AMERICAN NURSES ASSOCIATION
Report to the Board of Directors
On

TASK FORCE REPORT ON THE NURSE INTERSTATE LICENSURE COMPACT

CONSENT INFORMATION

EXECUTIVE SUMMARY: **The National Council of State Boards of Nursing has requested ANA to formally support the Nurse Interstate Licensure Compact or remain neutral. In response to this request, the ANA Board of Directors appointed a board task force to explore this request and make recommendations.**

PROBLEM/ISSUE STATEMENT:
The National Council of State Boards of Nursing (NCSBN) continues to request that the American Nurses Association (ANA) formally support the Nurse Interstate Licensure Compact (compact) or remain neutral. On February 24, 2005, members of the ANA Board of Directors task force on Interstate Compact, ANA staff, three interstate compact administrators, and NCSBN staff participated on a conference call to discuss the 1998 ANA House of Delegates resolution and the six outstanding points that have not been met. Several questions were raised by the ANA to which the compact administrators indicated they would supply more information.

BACKGROUND:
This follows a similar request made by the Chair of the Nurse Licensure Compact Administrators (NLCA) in 2003 to support the compact. In response to the 2003 request, the ANA Board of Directors (BOD) formed a BOD task force on the Interstate Compact in the spring of 2003. Following the recommendations of the task force, a letter was sent from President Blakeney to the Chair of the NLCA stating that there was no new information or data that would compel the BOD to seek to change ANA's current position on interstate practice. The ANA Board of Directors' task force reconvened via conference call in November, 2004 and made five recommendations on this issue.

In 1998 the House of Delegates passed a resolution on interstate licensure outlining fourteen points that must be met for ANA to support a licensure initiative. This resolution was reaffirmed in 1999. Following the 1998 Convention, ANA and NCSBN agreed each organization would

create a team to meet and discuss ANA's concerns about the compact. ANA and NCSBN released a joint statement related to the compact discussions between the two groups. Through these discussions, some of ANA's concerns were addressed however, the following six points of the fourteen points have not been resolved:

The state of predominant practice should be the state of licensure; if the nurse is not practicing, the nurse should be licensed in his/her state of residence. (HOD Policy #8.13, paragraph 4.1)

The state of practice rather than the state of residence is more logically related to the purpose of licensure which gives a nurse authority to practice. This corresponds to state authority related to other health care professions, state administrative agencies as well as state courts that have jurisdiction only over actions taken within the state.

The state of practice interest in protecting the safety of its citizen-patients is potentially better served because the home state (as the state of practice, and most likely the residence of any complainant) will be perceived as more likely to take aggressive discipline action against nurses who have treated state citizens.

Licensure in the state of practice is possibly more "user friendly" to the complainant, as well as conducive to the investigatory procedures when following through on complaints and performing investigations.

A nurse would better be able to defend against a complaint where practice occurred because of better access to witnesses and records.

Nurses employed by state governments may have policies requiring licensure in the state of practice. Licensure based on state of residence for those who live across state borders, is an untenable situation.

Interstate practice must not be implemented in a way that allows persons to circumvent or contravene existing public policy as expressed by a state's laws or policies, including laws on the use of strikebreakers and striker replacement or initial and continuing licensure requirements. (HOD Policy #8.13, paragraph 4n.)

Provisions in the compact require party states to unconditionally accept the licensure standards of other states which could lead to a "lowest common denominator" of state licensure standards. Remote states (party states other than the home state) would lose the ability to set licensure standards for nurses licensed in other states (party states) but practicing in their state. For example, while most states require a nurse to complete a formal nursing program in order to take the RN/LVN licensure exam, some do not. If two states with these differing requirements were to enter into the compact, the state with the requirement for the formal nursing program would be forced to accept the lower standard from the other state. This would result in varying standards of education in the same state. In addition, if a party state reduces it standards governing foreign educated nurses, this would result in every party state decreasing its standards as well.

This inconsistency of standards could also be applied to states that have differing continuing education standards. If a home state requires continuing education requirements, they would not be enforced for nurses licensed in remote states, while nurses licensed in the home state would have to meet the requirements. Nurses working side by side would then have different requirements for practice.

The same inconsistent application of standards applies to criminal background checks. States have differing background check requirements for initial licensure. States differ in the types of offenses that are considered prohibitive for licensure; and some states look at the age of the nurse and circumstances surrounding the criminal offense. Others review or assess the nurse's reputation and work since conviction. Thus, if state A's law prohibited licensure if one has been convicted of manslaughter and state B had a lesser more subjective standard which would require hearing and evaluation of the circumstances, the state with the higher standard would have to accept for licensure the nurse who passed the background check/criminal background requirements of a more lenient state if both were parties to the compact.

Likewise, states should consider the implications multistate licensure has upon statutory mandated drug diversion programs. Some states treat the programs as a condition for licensure and others treat the program as an adjunct to licensure. Thus, if one fulfills the conditions of the drug diversion program, his/her license is not removed. Others states take licensees through an adjudicatory process, and the licensee is granted a limited license while in the drug diversion program and has to go through another hearing after completion of the program for licensure reinstatement. None of the literature prepared by NCSBN nor the compact directors has addressed this concern.

Some state laws prohibit health care practitioners from pleading nolo contender to drug offenses; while other states allow flexibility and the ability to plead nolo contender, thus a nurse may have a record in one state for a drug offense while another nurse would not have a record in another state whose conduct was identical. Compact states have not addressed the treatment and disparities inherent in addressing drug diversion treatment created by the infrastructure of the compact.

With the implementation of the compact, boards of nursing may find it increasingly difficult to protect the public by ensuring safe nursing care. Boards protect the public not only through licensing and disciplinary functions, but also through interpreting and enforcing the state nurse practice acts. In compact states, boards would be required to monitor nurses over larger geographic areas, deal with multiple boards from other states, and carry out multistate discipline.

Although NCSBN believes that the electronic database NURSYS would provide adequate information to other states related to discipline, there has been no data collection on the cost of preparing a case for discipline in multiple states or on the amount of recovery of these costs by compact states. With the responsibility to discipline comes the responsibility and the financial burden of monitoring the multistate discipline. This would be done in an environment where boards are faced with declining budgets as states seek to resolve budget deficits. In addition, less

revenue will come from nurse licensure fees.

It is estimated that 12% of nurses hold multiple licenses therefore arguably all nursing boards could suffer an *average* of at least 12% reduction in revenue. And, if multiple licensed nurses hold licensure in more than two states, that impact is greater. In addition, boards have an additional financial obligation to the newly established electronic data base, NURSYS.

Approaches to interstate advanced practice nursing should be addressed for consistency in connection with interstate practice for other RNs (HOD Policy #8.13, paragraph 4.i).

Excluding APRN practice from the RN/LPN compact and establishing a separate APRN compact pose important challenges for the continued development of both RN and APRN practice. ANA has generally approached nursing as a continuum of practice and has rejected proposals to establish a separate, or "second" licensure for APRN practice. The compact model of APRN regulation is premised on the need to have a separate distinct license and a separate scope of practice.

Policy on licensure development is premised on the need to create licensure classes. The presumption is addressed by determining whether or not the health or safety of the parties using the services of the professional class has been harmed by the lack of licensure. Although nursing groups are pushing for this new class, there are no data to show that APRNs disproportionately jeopardize the health and safety of their patients or their clients.

The desire to create a rigid, second class of licensure is premised on the need for additional study by the nurse and tends to mimic the medical model, while totally discounting the nursing model, which compels all advanced practice nurses to have RN licensure and experience prior to entering an advanced practice nursing program.

The second licensure recommendation has been articulated as an administrative option to make regulation more efficient. Other options, short of creating a new licensure category exist to address administrative concerns articulated by the Boards of Nursing.

Mechanisms should be in place to ensure that a board of nursing knows who is practicing in its state under authority of a license granted by another state or through an interstate practice agreement; (HOD Policy #8.13, paragraph 4.k)

Since the party state does not require a nurse from a remote state to register with the board of nursing, the board will not know if a nurse is practicing in that state. This makes it difficult for the board to enforce the practice act as well as determine the quality of care provided by that nurse.

A party state could take action to limit the nurse's ability to practice in a remote state, but if the Home state failed to take action against the nurse's license, the nurse would be free to practice in any other party state without the board's knowledge. This limits the ability of the state to establish a regulatory means to protect the public, thus impacting state sovereignty.

The Registrar of the Alberta, Canada Association of Registered Nurses (Board of Nursing) outlined the difficulties she encountered when trying to verify practice of nurses in the United States. Alberta requires a nurse to verify practice in all regulated jurisdictions where she/he has worked. When working under the compact, the boards of nursing (in states other than the home state) do not know if a nurse has practiced in their state and cannot verify practice. This requires the home state to sign off on all practice jurisdictions which has lead to delays in confirming practice for nurses who want to practice in Alberta and has increased the administrative burden for the home state and the Alberta licensure board.

Many states are increasingly working to determine nursing supply and demand requirements especially related to the nursing shortage. Since a remote state nurse is not required to register with the board of nursing, the state will not be aware of the actual number of nurses working in the state making workforce projections difficult.

The right of individual nurses to a fair hearing of any disciplinary matter must be protected; and, no unfair or undue burden, financial or otherwise, should be placed on a nurse's exercising his/her right to a fair hearing; (HOD Policy #8.13, paragraph 4.h)

Nurses may find themselves subject to multiple investigations and disciplinary proceedings arising from the same incident. The nurse could be required to bear the cost of investigation and disciplinary proceedings. Due process issues also arise when a nurse has to represent him/herself in multiple jurisdictions at one time. There are also conflicting evidence standards for jurisdictions. Information and case requirements in one jurisdiction may not withstand scrutiny in another jurisdiction.

It is not clear what the result of the availability of parallel disciplinary processes is likely to be. How much weight is afforded by a remote state to an adverse action by the home state -- by the home state to an adverse action by a remote state? What kinds of incidents lead a Remote state to "limit or revoke the multistate licensure privilege of any nurse to practice in their state"—will these be the same kinds of incidents that lead to suspension or revocation of licensure in the home state? What is the relationship between the two kinds of actions?

The compact authorizes state boards of nursing to recover from a nurse the cost of investigations and dispositions of cases resulting from any adverse action taken against the nurse. This adds a financial burden to the nurse that is not the case with the current licensure system and is not required by other state licensing laws for any other occupation. And, it is questionable if this type of financial burden imposed by one state to address multiple state investigations violates due process. Again, it should be noted that neither NCSBN nor any other entity has conducted studies of the impact this cost has on licensure.

The rule-making process to implement any interstate practice legislation should be clearly spelled out in the legislation, and proposed implementation regulations of key provisions should be developed simultaneously with and legislation; (HOD Policy #8.13, paragraph 4.b.)

The Nurse Licensure Compact is the first compact to address licensure of individuals. Typically, compacts address environmental, correctional or safety issues; and compact administrators develop rules which may or may not require administrative review and approval. Our concerns arise because nurses are affected by the procedures developed by the compact administrators and those procedures may limit or circumscribe the rights of the licensee. We believe that little legal analysis or review has been directed to this due process consideration.

Since 1998, 21 states (AZ, AR, DE, ID, IA, IN, ME, MD, MS, ND, NE, NJ, NM, NC, ND, NH, SD, TN, TX, UT, VA, WI) have enacted compact legislation/regulation with only 20 being eligible. Indiana was ejected from the Compact because of incompatible language (it required nurses to register with the Indiana Board of Nursing every two years and pay a $25 fee). seventeen states have implemented the Compact – one in 1999; seven in 2000; five in 2001; one in 2002; one in 2003; two in 2004. Of the three states that have yet to implement the compact, two will implement the Compact in 2005; and the remaining state, New Jersey, has not determined a date.

Five states (KS, MO, NV, NH, and SC) introduced RN/LPN Compact language in the current state legislative session yet, New Hampshire was the only state to enact legislation. In addition to ANA's concerns about the compact, concerns have also been expressed on the state level by state nurses associations' boards of nursing, state attorneys general, nursing organizations and nurse administrators. This year, Utah became the first state to enact the APRN compact.

Since the first state entered into the compact in 1998, there has been minimal formal evaluation of the compact. In December of 2003, NCSBN provided an impact evaluation of the compact which included information from eleven boards of nursing in compact states. The boards were asked about numbers of multi-state and active licenses, revenue and expenses, and discipline-related information. One-hundred and fifty-six employers from thirteen compact states were surveyed to determine if the compact had made an impact on the hiring and retention of nurses they employed. Six hundred and fifty-five nurses from thirteen compact states were surveyed to determine the impact of the compact on their practice.

The evaluation provides some early data on the compact, but fails to address underlying issues raised by the ANA 1998 HOD resolution such as licensing a nurse in the state of practice rather than residence; overriding of state laws related to licensure requirements; requiring a separate and distinct license for APRN practice; failing to require a board to identify which nurses are practicing in their state; and the need for collecting more specific information relating to protecting the right of individual nurses to a fair hearing process.

While the Optional Enabling Act Provisions of the Interstate Nurse Licensure Compact would require the nurse licensing board to participate in a Compact Evaluation Initiative to evaluate the effectiveness and operability of the Compact by 2005, not every state has included this provision in their legislation.

CONCLUSION STATEMENT:

The ANA Board of Directors Task Force on Interstate Practice and ANA staff will continue to dialog on this issue and bring any new recommendations to the board. ANA has requested NCSBN to provide ANA any new data related to the compact when it becomes available. A status report on the compact will go forward to the 2005 House of Delegates.